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Introduction-Never the same crisis twice

Our intention is to design an effective resource for families, teams, and provider agencies when their capacity to provide meaningful, individualized support is challenged primarily by an individual's behavior. In some instances, this proposed safety net may be used when the precipitating event is the failing health, advanced aging or death of a parent. This model does not intend to address crises prompted by medical emergencies. We intend to accomplish this by providing technical assistance, training, and supplemental staffing. Through individual intervention we believe provider and systemic capacity will be strengthened.

Although our initial access to individuals and providers may be through crisis, our mission, over time, is to assume a proactive presence state-wide. We will emphasize prevention and enhanced capacity as we identify contributing trends and factors. We are integrating information into a comprehensive database that will guide future resource allocation and training.

Crisis Composition

We assert that crisis constitution varies widely across agencies and regions. We find that the nature of specific behavior, including type, frequency, duration, and intensity, is not the distinguishing factor in defining a crisis. The ecology of experience, capacity, will, competing demands and confidence of providers, and ancillary resource availability in addition to the individual's characteristics ultimately determine crisis constitution. We propose that any request for support, consultation, or technical assistance in response to an Interdisciplinary Team (IDT) perception of compromised capacity to provide meaningful, individualized support to an individual constitutes a potential crisis. In the course of intake, if the Office of Behavioral Services determines that services and staff are or will soon be jeopardized and diminished, or the Individual Service Plan (ISP) goals and objectives will be weakened, a formal crisis determination will be made. Subsequent response, including Tier I, II, and III, will then be offered under the proposed system. The Tiers are more fully described below. One objective in fielding a request for crisis response/capacity building is assessing existing IDT competency and efforts, not simply noting problem behavior. However, response effectiveness will be examined and tracked relative to the behaviors initially noted in addition to enhanced capacity.

Currently, the majority of requests are addressed through the assistance of the Office of Behavioral Services working in conjunction with the Behavior Therapist and IDT.

The following challenges are frequently cited as prompting a request for crisis response:

- Severe aggression toward others.
- Severe self-injury.
- Repeated elopement.
- Absence, shortage, or marginal competence of available resources, most notably medical, psychiatric, and behavior therapy.
- Sexual aggression including criminal perpetration.
- Illegal behavior ranging from misdemeanors to felonies.
- Drug and alcohol abuse.
- Acute mental health incident often prompted by unadvised discontinuation of psychotropic medication.
- Current or impending homelessness.
- Aging and/or failing health of family members, most often parents, providing support.
- Individual vulnerability to exploitation.

We propose organizing behavior into impact/risk characteristics; that is, the likely effect the behavior produces rather than the specific behavior. This is consistent with the database and proposed site visit/effectiveness evaluation protocols under development. The impact risk characteristics are:

Distracting behavior: Behavior that others find annoying, "pesky," negative, and undesirable but do not imminently cause significant harm. Some individuals present distracting behavior with such frequency and intensity that finding and retaining staff and maintaining family and peer relationships is compromised. This behavior may also exclude participation and mere presence in many community settings. Active examples include perseverative questioning and comments, offensive language or gestures, constant touching, and unusual self-regulating behavior. Passive examples include refusing to participate in activities, refusing to enter/exit vehicles or settings, and physical and personal withdrawal.

Disruptive behavior: Behavior that interrupts habilitative support, creates a potential vulnerability for the individual, is potentially harmful to self or others, and calls significant negative attention to the individual. This typically not only disrupts desired support for the individual but for peers as well. Support becomes increasingly organized around intervention and management with decreasing attention to ISP habilitation goals. Examples include verbal aggression including threats, poor decisions about health and safety, poor hygiene, questionable choices for friends and/or sexual partners, financial disregard, obscene remarks and behavior, drug and alcohol abuse, minor property damage and chronic refusal of services.

Destructive behavior: Behavior that historically has caused physical and/or great emotional harm. The acts may harm the individual or may be directed toward peers, staff, family, and community members. A typical result is that all support is reactive and

designed to control the behavior. The individual usually is given fewer activity, environment and relationship options due to the real or perceived risk. Examples range from reparable tissue damage to potentially lethal acts, including violent sexual aggression. The extreme episodes may be intermittent or chronic. Some individuals have presented similar extreme behavior literally for decades. Some episodes of substantial property damage, such as fire starting are also considered.

Initial Response

Our initial task is to determine the individual's behavioral and mental health status and the environmental factors that prompt, contribute to, and/or sustain the situation. The individual's behavior is frequently an artifact of the relationship between their needs and environment. We will examine both internal and external variables. Those setting factor determinations will then inform subsequent crisis response/capacity building. Please refer to the attached grid entitled, *Setting Considerations,* for organization. The factors are considered across four domain areas; personal characteristics, environmental considerations, interpersonal factors, and activity accommodations. These domains will be assessed across the following three levels of support and intervention. The primary focus of support is **habilitation**-what efforts, methods, resources, and expertise are devoted to enhancing the individual's autonomy, choices, pleasure, safety, and capacities in accordance with their dreams and aspirations. This is the essential teaching, mentoring and guidance aspect of Individual Service Plan goals and objectives. There are times when staff must assert a level of **management** to maintain situations, redirect individuals, and reduce the probability of behaviors escalating. Management strategies are primarily proactive but assume a shift in focus toward behavior with the intent of returning to habilitation efforts as soon as warranted and possible. Finally, on limited occasions, staff are responsible for **control.** This is the last resort, often comprising reactive crisis response and implementing crisis strategies to prevent imminent harm to the individual or others.

The accumulative setting factor information explores the degree to which the IDT understands and accounts for considerations in each of the four cited domains and the necessary additional or amended considerations when moving between habilitation, management, and control. Crisis response/capacity building response will target the areas of greatest need and potential effectiveness.

Considerations for each domain are described below:

Personal Characteristics

This domain records personal attributes and characteristics that must be accounted for at all times, particularly when considering the potential for challenging behavior. These attributes must be accommodated at each level of support and intervention. The following are most important:

- Communication capacity, preference, and style
- Social competence
- Comfort rituals and self regulation

- Problem-solving ability
- Sensory integration and sensitivities
- Stress management skills
- Emotional status: longer arcing affect and short term mood
- Medical/physiological complications, including syndromal effects
- Somatic status
- Medication implications, including tardive dyskenesia
- Sexuality needs and expression
- Spiritual/aesthetic sense
- Cognition: ability to organize information in a functional manner

Environmental Considerations

This domain records physical space considerations that create comfortable, safe, organized settings for an individual. As above, each level of support and intervention may require adaptations which must be accounted for. Some vital considerations include:

- Size
- Visual organization
- Level of multi-sensory stimulation
- Indoor v. outdoor
- Activities associated with particular settings and areas within settings
- Expectations associated with a particular environment
- Clear physical cues regarding movement

Interpersonal Factors

This domain records the relationships available to the individual, the nature of interactions, providers/staff competence and attitude toward the individual. Again, a thoughtful approach to each level of support and intervention must be considered separately with the following:

- Caring support: caring about the individual in addition to caring for them
- Trusting relationships: promises are kept, staff behavior is predictable, responses are respectful
- Freedom from coercion
- Balance between guidance and challenge-knowing when to assist and when to encourage
- Differences are noted in relationships with staff, peers, friends, and family
- Profiles of characteristics the individual finds attractive are noted
- Communication consistent with the individual's preferences and capacities will be used
- Tasks and activities are presented as cooperative endeavors
- A variety of paid and unpaid relationships are available or sought
- Staff are informed and trained regarding the individual's support needs
- Staff are competent at implementing support needs

Activity Accommodations
This domain records the variety and range of activities available to the individual. It assumes personal care, recreation, vocational, community membership and all other habilitative efforts. Some considerations include:

- A sense of meaning and purpose for the individual
- A balance between structure and predictability v. variety and novelty
- Expectations and intentions are clearly expressed
- Activities are goal oriented according to the Individual Service Plan
- A balance between guidance and challenge is sought
- Learning style and pace are accommodated
- Teaching strategies and resources are clear
- The difference between what is important to the individual v. what is important for the individual is understood

The existing Tier system framework will continue to define levels of response. Each Tier is designed to develop strategies and support beginning with the least restrictive and intrusive intervention and evolve into more restrictive and intrusive intervention only when necessary to preclude imminent egregious health and safety risks.

Tier I: This is primarily a technical assistance and training intervention. It includes a global assessment of the above setting factors that contribute to episode initiation and maintenance. The factors will be organized and tracked according to personal, environmental, interpersonal and activity characteristics. Subsequent intervention strategies will link to each factor. Staff mentoring and team facilitation, consultation and guidance for the Behavior Therapist of record, interim Behavior/Crisis Support Plan development when a behavior therapist is not assigned, resource identification, referral for specialized screening and assessments, and custom training are additional activities under Tier I. Tier I response will be provided by all Office of Behavioral Services staff.

Tier I intervention is most appropriate for, but not limited to, distracting and low frequency/intensity disruptive behavior. However, Tier I intervention has also been successful in many circumstances involving destructive behaviors that providers and teams are unable to address. Intervention may consist of a single IDT meeting or a series of events over a period of months.

Termination criteria for all Tiers will be mutually identified between the requesting IDT and OBS. Unresolved expectations will be noted with OBS having final authority in determining when to discontinue or amend intervention.

Tier II: All Tier I activities are available in Tier II. The essential distinction is the option of enhancing Tier I intervention with supplemental staffing. It is not intended to fill provider staff shortages or failure of providers to use on-call or back-up staffing plans.

This responsibility will be assumed by the proposed Psych Techs. Their role is to augment existing staff and act as on-site trainers and mentors when the experience and expertise of existing staff is not effective. The Psych Techs will also be responsible for a more thorough description of the setting factors. When the expertise of the local Psych Tech or demands of the situation require additional resources, Psych Techs from other regions may be assigned out of region.

Tier II intervention is most often employed for more significant disruptive and low frequency/intensity destructive behavior. The duration and intensity of the Tier II intervention will be assessed weekly once initiated.

Tier III: All Tier I and Tier II activities are available in Tier III. The essential distinction is the option of crisis response/capacity building staff assuming primary or exclusive staffing responsibility. At times, the setting will not change and provider agency of record staff will be removed. In other instances, the individual will be temporarily relocated to an alternative setting. Available resources will be assessed to determine the least disruptive option. The preferred outcome of effective Tier III intervention is restoring the individual's pre-crisis supports and providers. Tier III intervention is designed to be a short-term response of a 2-90 days. This may be exceeded in extraordinary circumstances as agreed to by the IDT and OBS in consultation with LTSD. Also, there are situations that warrant a comprehensive change in support providers, IDT composition and membership, goals and objectives.
Tier III is most appropriate for destructive behavior. However, Tier III will also be implemented when intake or referral information suggests a pervasive and persistent failure on the part of providers to discharge their responsibilities or provide essential health and safety accommodations. The duration and intensity of the Tier III intervention will be assessed daily once initiated.

We reiterate our finding that crisis constitution, and as a result corresponding response, is a multi-modal phenomenon and is not determined exclusively by the presenting behavior. Therefore, the presence of a particular risk/impact finding does not automatically determine a particular Tier response.

Follow Up

Each Tier II and Tier III and a sample of at least 10% of Tier I interventions will be tracked over time for status and effectiveness. The following survey will be completed by the OBS proposed Administrative Crisis Coordinator and is consistent with the emerging database. The results will be tracked for individual outcomes, intervention type and effectiveness, regional distribution, subsequent adaptations of the crisis response/capacity building system, and provider outcomes and use trends.

1. Describe the circumstance prompting a request for crisis response/capacity building services. Please note if more than one request was made.

2. Were you able to contact crisis response/capacity building services in less than 24 hours?

   YES NO-how long?

3. Did a respondent initiate intake within 24 hours?
   YES NO-how long?

4. Did you receive a proposed initial response within 24 hours?
   YES NO-how long?

5. Identify the proposed Tier or Tiers and designated activities.

6. Did you agree with the proposed response?
   YES NO-please explain

7. Did you proceed with Crisis Response services?
   YES-please continue NO-please explain

8. Was the Crisis Response effective in addressing or resolving the referral question?
   YES-why No-why not

9. Do you believe the individual's support is enhanced by this experience, including the IDT's capacity to prevent or respond to future similar circumstances?
   YES-please describe NO-please explain

10. Do you believe the IDT's capacity to prevent or respond to future similar circumstances with other individuals is enhanced by this experience?
    YES-please describe NO-please explain

11. Please include any critical or constructive feedback to enhance crisis response/capacity building services.

Recommendations

OBS will assume principal responsibility for crisis response and provider capacity building.

- The current Regional Behavior Specialists and proposed Psych Techs will field inquiries and requests during business hours. A single contact phone/pager for each region will be dedicated and advertised.
- A state-wide on-call system will be used for weekends, evenings and holidays. Financial compensation will be provided for on-call rotation. A single state-wide contact phone/pager will be dedicated and advertised.
- The proposed Administrative Coordinator will manage the database and execute follow-up surveys.
- The proposed Psych Techs will be trained by OBS.

Phase One: Begin immediately-To be completed by 6/30/05

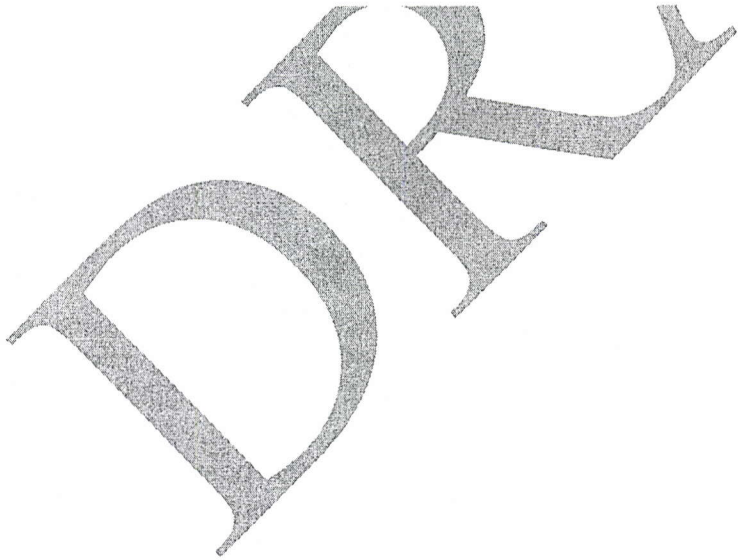
- Establish OBS as central point of triage and administration. Inform appropriate referral sources.
- Recruit Crisis Supervisor with the following responsibilities:
    - Oversight and supervision of crisis response/capacity building
    - Technical and clinical assistance
    - Training-IDT, OBS, and LTSD
    - Interagency and IDT liaison
    - Database manager of record
    - Lead role in hiring and training of Psych Tech positions
    - Monitor and report intervention effectiveness
    - Occasional crisis response
- Recruit Administrative Crisis Coordinator with following responsibilities:
    - Intake
    - Triage and coordination
    - Training schedules
    - Data entry
    - Data management
    - Data reporting
    - Follow-up, progress and outcome reporting
    - Quality assurance reporting
    - Occasional Tier I intervention
- Maintain management of Tier I, Tier II through Regional Behavior Specialists and Regional Managers, LLPC and/or Consortium Providers as needed.
- Maintain technical support for Tier II from LLCP and OBS.
- Maintain LLCP and Consortium providers as Tier II responders.
- Maintain LLCP as Tier III provider.
- Form Regional Crisis Response Teams (3-5) statewide:
    - Team members:
        - Regional Behavior Specialist (4 current, 1-2 additional)
        - Direct Support Specialist (5-6 Psych Tech positions requested)
        - Regional DD Nurse (Current Regional Office)
    - Identify potential members for at least three teams
    - Train and mentor team members
        - Comprehensive initial assessment information skills
        - Setting consideration framework skills
        - Physical crisis management skills
        - Consultation strategies
        - Six essential person-centered thinking skills (Essential Lifestyle Planning)
    - Pilot process in Metro, and two other selected geographic areas.
- Modify provider contracts to move funding for FY06 to support revised response process.
- Establish database to consistently track requests for service, response and outcomes.
- Evaluate response effectiveness and trends, including the potential need for psychotropic medication, mental health and/or medical expertise.

Phase Two: Begin 6/30/05-To be completed by 12/31/05: Based on Phase One analysis

- Maintain OBS as central point of triage and administration.
- Modify crisis response/capacity building team structure/membership/training based on Phase One analysis.
- Expand from three to six teams statewide if justified, to address geographic/population based needs.
- Redirect funds formerly earmarked for the Consortiums.
- Provide training and technical assistance, using the Psych Techs and other Regional Crisis Team members to proactively support vulnerable individuals and IDTs exhibiting factors predisposing crisis.
- Maintain technical support for Tier II and Tier III from LLCP and OBS.
- Maintain LLCP as Tier III provider.
- Address Tier I and Tier II through use of the Regional Crisis Response Team(s) under the direction of the OBS in collaboration with Regional Managers.
- Request Legislative authorization to convert contracted Psych Techs to FTE and to add FTE for state to become a specialized residential/respite service provider.

Phase Three: Begin 12/31/05-On-going: Based on Phase Two analysis

- Maintain OBS as central point of triage and administration.
- Provide ongoing training and technical assistance emphasizing provider capacity building through Regional Crisis Teams and OBS.
- Establish state operated regionally based residential/respite service/Tier III programs, determined by data analysis of need.
- Secure funding to maintain staff/space to support individuals in crisis within state operated regional programs.
- Maintain technical support for Tier I, Tier II, and Tier III from OBS.
- Maintain LLCP as Tier III provider for Metro area.
- Establish capacity and authority for state operated programs to assume permanent responsibility for 5-8 individuals annually who are extraordinarily challenging to serve or experience repeated crises with other providers.



Setting Considerations			
	Personal	**Environmental**	**Interpersona**
Habilitation			
Management			
Control